Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $400.00 for dates of service commencing on 01/28/02 and extending through 02/14/02.

   b. The request was received on 05/30/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. Medical Audit summary/EOB/TWCC 62 form
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 09/27/02. The respondent did not respond to the additional documentation. It's initial response is reflected in Exhibit II.

4. Notice of letter requesting additional information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 05/15/02

   "The listed claims have been disputed by the insurance company for the reason of documentation does not support the level of billed service. I dispute their claim with the following point. On each patient encounter the following procedures are performed.

1. A problem focused history or consultation is done to ascertain any change in condition or symptoms and concerns….
2. In a problem focused exam, a palpation of the spine is done to assess spinal biomechanics and biokinetics…
3. Once these procedures have been completed a decision is made regarding the need for a specific chiropractic adjustment to specific vertebrae or other skeletal structures is established and then the chiropractic adjustments are rendered.
4. Following the chiropractic adjustment a post adjustment assessment is done to determine if the desired result has been accomplished…"

2. Respondent: No position statement found.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 01/28/02 and extending through 02/14/02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Provider billed the Carrier $400.00 for services rendered.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Provider $0.00 for services rendered.

5. The Carrier's EOBs deny reimbursement as, "N11 Not Documented. Upon review, documentation as submitted does not support the level of services(s) billed."

6. Per the Requestor's Table of Disputed Services, the amount in dispute is $400.00 for services rendered on the dates of service in dispute above.

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
01/28/02 01/29/02 01/31/02 02/04/02 02/05/02 02/06/02 02/07/02 02/11/02 02/12/02 02/14/02	99213 MP 99213 MP 99213 MP 99213 MP 99213 MP 99213 MP 99213 MP 99213 MP 99213 MP 99213 MP	$40.00 $40.00 $40.00 $40.00 $40.00 $40.00 $40.00 $40.00 $40.00 $40.00	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00	N for all dates	$48.00	MFG E/M GR (IV) (C); CPT Descriptor	The carrier has denied the charges in dispute, as "N11 Not Documented. Upon review, documentation as submitted does not support the level of services(s) billed". The MFG states CPT Code 99213 "requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity." The very limited SOAP notes submitted do not reflect the documentation requirements listed in the MFG. The provider's verbiage appears to be essentially the same from date to date and no note is made of the manipulations. The provider has failed to submit medical documentation to support services billed in accordance with the MFG for reimbursement. **No** reimbursement is recommended.
Totals		$400.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 31st day of October 2002.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt